

Children, Adolescents, and Isolated Traumatic Events: Counseling Considerations for Couples and Family Counselors

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Abstract:

This article presents considerations for marriage and family counselors assisting children and adolescent clients who have witnessed or survived an isolated traumatic event or who have family members who have witnessed or survived an isolated traumatic event. Direct emotional outcomes in children and teens related to isolated traumatic events, such as separation anxiety disorder and post-traumatic stress disorder, also are presented. In addition, specific clinical interventions—including the use of play therapy, psychoeducational groups, and cognitive-behavioral therapy—are presented as specific methods for assisting children and teenagers coping with traumatic events in a variety of settings.

Keywords: trauma witnesses; post-traumatic stress disorders; natural disasters; children and adolescents; play therapy

Article:

The news of the devastating effects of hurricane Katrina in August 2005, tsunamis and earthquakes in Southeast Asia, commercial aircraft accidents, violence in the Middle East, and isolated terrorist attacks in Europe are but a few of the topics currently being reported on the evening news, print media, and available for download from the Internet. Combined with the tragedies of September 11, 2001 and the Columbine High School shootings, it is reasonable to consider that images and personal experiences related to these natural disasters and violent acts can cause trauma in children and adults alike. Whether a direct victim of these events, direct witness to the events, surviving family member, or seeing the events played out on a television, these occurrences may have a direct and unpleasant impact on individuals being exposed to them (Cook et al., 2005; National Institute of Mental Health, 1999). In light of recent advances in telecommunications and web-based media, more and more people are becoming visually and rapidly aware of tragic world events through live television broad-casts and the Internet (Shen & Sink, 2002). Consequently, those individuals who have borne witness to a traumatic event or have survived a traumatic experience have been the subjects of counseling and psychological interventions and clinical studies for several years (i.e., Shelby & Tredinnick, 1995; Shen & Sink, 2002; Terr, 1979, 1991). Couples and family counselors should consider the relationship between youth and isolated traumatic events because of current historical events and the reality that trauma manifests itself differently in children compared to adults (Armsworth & Holaday, 1993) and that trauma can be a greater blow to children because of their developing cognitive, social, and emotional maturity (Scheidlinger & Kahn, 2005).

Traumatic events can be violent, catastrophic, and agonizing experiences, which may be isolated incidents or pro-longed episodes (Ogawa, 2004). The authors will focus on the impact of directly or indirectly experiencing isolated traumatic events. For the purposes of this discussion, trauma will be defined as the fear and anxiety that comes with a loss of control because of an unplanned and life-altering event, for which there is no simple explanation and which leads to feelings of potential danger in daily life (Bronfman, Campis, & Koocher, 1998). Furthermore, information will be limited to children and adolescents' traumatic reactions to natural disasters, terrorist attacks, and other violent events—such as school shootings, reactions to sexual or physical abuse, observing domestic violence, or witnessing a car accident— will not be discussed.

FACTORS RELATED TO ASSISTING YOUNG WITNESSES AND SURVIVORS OF TRAUMATIC EVENTS

Physically or personally experiencing natural disasters and acts of violence, as well as watching them on television, can result in several mental and physical reactions and symptoms such as post-traumatic stress disorder (PTSD), depression, violent actions, attachment disorders, sleep disorders, and feelings of helplessness and hopelessness (Armsworth & Holaday, 1993). In the aftermath of the 2005 U.S. hurricane season, which spawned hurricanes Katrina and Rita, mental health professionals were called on by relief agencies and professional associations to provide their services to children and families who had survived the fury of the storms yet lost their material possession, homes, and loved ones in the process (Church, 2005). Even those individuals not directly impacted by the storm, particularly children, were being advised to seek the assistance of mental health professionals in an effort to deal with their emotions in relation to traumatic events on television or the Internet (Church, 2005).

Several factors regulate the psychological impact of isolated traumatic events on children and adolescents. A young person's age and related psychological maturity has implications for how they might respond to trauma, with younger children being more confused and scared by isolated events (Shelby & Tredinnick, 1995). Physical distance from the traumatic event also plays a role in how children will react to trauma; indeed, their physical proximity to natural and violent turmoil is relevant to their biopsychological reactions (Goodman, 1996). In addition, whether a child's family member was hurt or died as a result of the trauma will have bearing on their current and future behaviors (Lew, 2002).

According to Armsworth and Holaday (1993), PTSD is the most common diagnosis for the trauma-related symptoms and behaviors in adults. However, they reported that children and adolescents directly impacted by traumatic events do not always show the same reactions to trauma as adults. Rather, Armsworth and Holaday noted youth, partially because of their cognitive development and maturity at the time of the traumatic occurrence, displayed a variety of cognitive, emotional, and behavioral responses to losing a loved one and surviving a natural disaster. Cognitive reactions to trauma in children included memory impairment and false realities, thought suppression, delayed or incapacitated learning, poor academics, and feelings of a bleak future. With regards to emotional responses to trauma, children experienced depression, guilt, feeling overwhelmed and confused as to why these types of things occurred, helplessness, and fear. Finally, aggression toward peers and adults, withdrawal from social settings, attachment to loved ones, bedwetting, and repetitious movements and play were common behaviors exhibited in children who had experienced traumatic events. Armsworth and Holaday acknowledged that, although some of these reactions are similar or identical to PTSD criteria, their frequency and intensity in children is what distinguishes them from being lumped under a PTSD diagnosis. However, it must be

stressed that children can be correctly diagnosed with PTSD in certain cases (Feeny, Foa, Treadwell, & March, 2004).

As an emotional and physical reaction to traumatic events, and compared to PTSD, separation anxiety disorder (SAD) is a more common and less controversial psychological disorder in children who have experienced a tragic experience; however, SAD has not been as thoroughly studied in relation to post-disaster reactions in children (Hoven et al., 2004). Hoven et al. considered the amount of time that had passed between the attacks and their study, the child's gender and race or ethnicity, family's exposure to the attacks, the child's age, and how close these children were to Ground Zero (the World Trade Center site). Hoven et al. were able to determine from interviews with parents that girls, young children, and children with previous exposure to traumatic events were more likely to be experiencing stress and SAD related to the attacks of September 11th.

Counseling implications and interventions for couples and family counselors are sparse in spite of the research on how isolated traumatic events affect youth. Some authors (Fairbrother, Stuber, Galea, Pfefferbaum, & Fleischman, 2004; Schonfeld, 2004) have questioned the level of readiness and willingness on the part of practicing counselors in effectively helping these young survivors and witnesses of traumatic events. As a result, the following section outlines different counseling techniques and clinical options for couples and family counselors.

COUNSELING INTERVENTIONS WHEN ASSISTING CHILDREN AND ADOLESCENTS COPING WITH TRAUMATIC EVENTS

Couples and family counselors—in addition to mental health counselors, psychologists, school counselors, psychiatrists, and other mental health specialists—can serve the needs of traumatized youth in one of two capacities: directly through counseling interventions and indirectly through consulting with other professionals. Play therapy, cognitive-behavioral therapies (CBT), critical incident stress debriefing (CISD), and group work are presented as four methods for couples and family counselors to consider in clinical practice with young clients experiencing trauma-related mental health concerns. Classroom Crisis Intervention (CCI) also is presented as a consultation methodology with school personnel.

Play Therapy With Young Survivors and Witnesses to Isolated Traumatic Events

Play therapy is often mentioned as an effective and beneficial treatment option when working with younger clients, particularly young and nonverbal children, for the treatment of disaster-related trauma (Armstrong & Holaday, 1993; Ogawa, 2004; Shelby & Tredinnick, 1995; Scheidlinger & Kahn, 2005; Shen, 2002). Ogawa further advocates for play therapy because of "limitations when working with younger children who often possess limited cognitive, abstract thinking, and expressive language skills" (p. 20). Although many reasons abound as to why a counselor should use play therapy and techniques with these children, the most often cited motivation for the use of play is how natural it is for children to communicate in this way. Shelby and Tredinnick noted how some children who survived or had repeatedly witnessed the devastation related to the Hurricane Andrew in 1992 could not talk about it; however, given dolls, crayons, paper, and other toys, the children seemed to open up with crisis counselors. Shelby and Tredinnick further stated that children felt they were able to re-establish their sense of control over their surroundings through the physical manipulation of arts, crafts, and toys. Shelby and Tredinnick concluded their study by indicating that play therapy allowed younger children to purge themselves of irrational and somewhat violent thoughts, which they would not have been able to do through standard talk therapy. Shen found similar results when working with Taiwanese children who had experienced trauma as a result of an earthquake in 1999. Shen used play

techniques as part of a person-centered group activity wherein the activity helped children experience a reduction in stress and depressive thoughts related to the earthquake. Ogawa and Bronfman et al. (1998) also have proposed the use of play therapy techniques (e.g., arts and crafts, drawings, and family portraits) to increase the coping skills of young survivors and witnesses of domestic violence, school shootings, natural disasters, traffic accidents, and serious medical procedures.

Couples and family counselors using play therapy techniques in their work with traumatized youth must find ways to integrate arts and crafts, manipulatives and toys, books and stories, and even writing tasks. Play therapy with a traumatized child begins with establishing rapport and trust (Falasca & Caulfield, 1999). Next, the counselor presents the child with an opportunity to talk about their feelings related to the isolated traumatic event while providing the child with toys, art and writing supplies, and dolls. By allowing the child to displace or project their feelings about the traumatic event onto the toys and crafts, the counselor follows the lead of the child as they learn to express and deal with the traumatic event. Couples and family counselors should speak with family members to assess their reactions to the traumatic events and how these reactions interrelate with the child in question to assess the impact of the traumatic event on the family system (Falasca & Caulfield, 1999). Subsequently, couples and family counselors may want to speak with teachers, school counselors, and other adults directly involved with the child to ascertain which social systems are being affected by the traumatized child. Finally, couples and family counselors also should check their arts, crafts, toys, and other supplies prior to starting treatment to ensure that family-related items (e.g., a family of dolls, books about families, stencils for every member of a family) are included.

CBT With Young Survivors and Witnesses to Isolated Traumatic Events

In general, CBT is an effective technique for helping children traumatized by tragic events. Couples and family counselors can use CBT techniques to establish how a child's belief system relates to schemata for processing traumatic events as well as how these schemata influence detrimental thoughts and actions (Falasca & Caulfield, 1999). This process provides the foundation for counselors to help the child develop more beneficial schemata and coping skills for dealing with memories or thoughts related to the isolated traumatic event. In addition, Feeny et al. (2004) established that CBT and related techniques have been empirically proven to benefit the emotional well-being of young clients suffering from trauma-related psychological concerns such as PTSD. Relaxation techniques, problem solving, aggression management, grief resolution, narratives, and stress inoculation are examples of ways to help children and teens cope with natural disasters (Feeny et al., 2004). Feeny et al. also supported the use of psychoeducational groups where children experiencing trauma-related symptoms can meet, share their stories and reactions, gain a sense of cohesion and universality, and learn how to better cope with their feelings, thoughts, and behaviors. When using CBT with individual children or groups, Feeny et al. found that short-term counseling (i.e., 4 sessions) was as effective as treatments involving larger numbers of sessions (i.e., 12 sessions). Also, group interventions were as successful as individual counseling interventions in treating children's symptoms. Finally, the authors found that starting the counseling process soon after the disaster or traumatic event was more effective in the long term.

Couples and family counselors familiar with CBT treatment options are advised to start counseling children who have witnessed or survived a traumatic event as soon after the event as possible (Silva et al., 2003). Specifically for couples and family counselors working with children and trauma, clinicians can use CBT to assess how children established harmful schemata and if they have reached a point where they cannot function in various systems as a result of the trauma. For instance, CBT in a couples and family clinical setting may involve asking the child what they believe the likelihood is of a similar

traumatic event impacting their family in the near future, the frequency of the event, and the severity of the event. The clinician can then determine how to challenge the child's thoughts and reactions (e.g., bouts of crying, inability to sleep, not wanting to be separated from a parent) to these thoughts by carefully helping the child reframe and rework negative schemata. All the while, counselors are encouraged to help the child face their trauma (Falasca & Caulfield, 1999), which may be facilitated by having children focus on positive aspects of themselves and enhancing their self-esteem (Silva et al., 2003). Parents and family members who survived and witnessed the same isolated traumatic event also should be contacted by the clinician to explore how their schemata may be influencing the child in question. Family counseling with relevant family members using CBT also is recommended when it appears that the family unit would jointly benefit from a safe forum to share fears, anxieties, and behaviors in response to the traumatic event.

CISD With Young Survivors and Witnesses to Isolated Traumatic Events

CISD and crisis counseling provides victims with an opportunity to process their grief, stress, anxiety, fears, frustrations, concerns, and worries, in an isolated counseling session. Jordan (2002) advocated for crisis counseling and CISD as specific counseling interventions used by couples and family counselors responding to the needs of students and staff at a college close to Ground Zero, as a result of the September 11th, 2001 terrorist attacks on New York City. Specifically, Jordan recommended that couples and family counselors responding to isolated traumatic events such as terrorist attacks consider crisis counseling and CISD as representing a form of "mental health first aid" (p. 141). CISD and crisis counseling in Jordan's case lasted for up to 3 hours in one session, usually occurred in groups, was administered by two or more clinicians, and was presented soon as possible after the incident. Jordan did not directly specify these types of crisis interventions for use with children and adolescents; however, she encouraged couples and family counselors to consider how directly (they themselves were injured, their family members were injured or died, they knew someone who was a casualty of the event) or indirectly (they read about the incident in the newspaper, heard about it from a friend, saw it unfold on television) clients were impacted by the event, in addition to the client's personal-social development, family composition, capacity to deal with other life stressors, and level of resiliency.

Considerations for using CISD with children in a couples and family setting would include a determination of how the age of the child, their maturity level, and their proximity to the traumatic event would affect the length of a counseling session or delivery in a group versus individual setting. Young children would probably not be capable of sitting through a 90 to 180 minute counseling session, whereas more mature youth could possibly benefit from longer sessions. Younger children may also benefit from more one-on-one assistance immediately after the traumatic event while older children may appreciate the added insight of peers in a CISD group. Couples and family counselors also could explore the implications of crisis counseling and CISD with an entire family. Perhaps younger children could focus for longer periods of time in a CISD session if parents, guardians, and other family members were participating with them. Finally, it may be helpful if couples and family counselors used CISD and crisis counseling techniques in conjunction with other providers (e.g., community counselors and school counselors) and familiar settings (e.g., community center and schools).

Group Work With Young Survivors and Witnesses to Isolated Traumatic Events

According to Scheidlinger and Kahn (2005) there are several types of groups used to treat trauma-related symptomology in children including support groups, crisis intervention groups, groups for children of alcoholic families, bereavement groups, and groups for medically ill children. Although the focus of

these groups differ on the presenting needs and counseling goals of participants, commonalities include the use of CBT, the use of play techniques, the need to establish rapport and trust between children and group leader(s), the acquisition of coping skills, and confronting the traumatic event in sessions. Pynoos, Goenjian, and Steinberg (1998) developed a group work therapeutic model for young victims and witnesses of large traumatic events wherein interventions are administered in three steps: (a) large group, psychoeducational sessions with classroom or schoolwide assemblies led by school personnel and consulting mental health specialists in which children are encouraged to ask questions and share reactions to the event; (b) instituting small group counseling interventions with youngsters experiencing continual stress, confusion, and reactions to the traumatic event that were not resolved through large group interventions; and (c) individual counseling with mental health specialist in the community for children suffering from severe depression as a result of the event.

A couples and family counselor involved in group work with traumatized children may decide which step of the Pynoos et al. (1998) model they would prefer to be involved in, or they may design their own group intervention for children in their community suffering from mental health issues related to the event. In either case, the couples and family counselor should focus on a psychoeducational approach for helping group participants learn appropriate coping skills (Scheidlinger & Kahn, 2005). Coping techniques are particularly important in group work in that they may be learned from group leaders or group peers, and may be practiced in the safe surroundings of the group environment in an effort to increase application of these techniques in outside social systems. Couples and family counselors may also elect to focus on how different families have dealt with the isolated traumatic event by encouraging youngsters to share their families' thoughts, reactions, and behaviors postevent. Both of these discussions can increase universality in group members, helping them realize they and their families are not alone in their struggles to grasp the magnitude and reason for the traumatic event. As with previously discussed interventions for couples and family counselors, clinicians should consider the role of family members in group work. Although it may be logistically difficult for one or more couples and family counselors to simultaneously work with a group of children (e.g., 5 children) and their families for an entire group work unit (e.g., 10 sessions), perhaps parents and guardians can be invited to participate in the last group session so that adults and children can determine how best to apply group experiences in the home.

Consultation and Young Survivors and Witnesses to Isolated Traumatic Events

Schools are one of the most common settings for couples and family counselors to serve as consultants in response to isolated traumatic events. Hoven et al. (2004) and Fairbrother et al. (2004) have shown that schools are one of the first places where children suffering from disaster-related trauma get assistance for their symptoms. Similar to Jordan's (2002) work in a college setting, Hoven et al. and Fairbrother et al. challenge couples and family counselors to assist children and adolescents in a familiar, centralized location such as their schools. In addition, the hindering thoughts and behaviors in youth linked to surviving or witnessing a natural disaster or violent act often manifest themselves in the school setting (Armstrong & Holaday, 1993).

Brock (1998) believed bringing crisis counseling interventions into classrooms was an effective form of dealing with a schoolwide or community-wide catastrophic event. Serving as consultant, Brock emphasized a crisis team approach composed of two or three school staff members to conduct CCI, aided by counselors from the surrounding community. School staff members—such as teachers, school counselors, administrators, and paraprofessionals—were trained in crisis interventions and crisis

management by counselors from the community (which could involve local couples and family counselors). The main role of the counselor-as-consultant was to conduct the training and be available for necessary feedback. Training consisted of how to help children talk about their fears and worries, helping children cope with their anxiety or loss, classroom management through difficult topics, and facilitating communication between students in a time of crisis. Training also involved carrying out the six steps of CCI (i.e., introduction of CCI team, providing facts and dispelling rumors, sharing stories related to the occurrence, sharing reactions to the traumatic event, empowering students, and closure). According to Brock, the ideal CCI experience should take 3 consecutive hours and occur as soon after the traumatic event as possible. Once the interested staff members were trained in CCI, teams of two or three staff members would be on call to go into classrooms in case of an incident, such as a school shooting or a natural disaster. In the unique occurrence that a violent act occurred in a particular class-room or involved children from a particular classroom, the classroom teacher would not be involved in the CCI for that classroom if he or she was a member of the CCI team. Finally, counselors-as-consultants should persuade CCI team members to contact the parents of children most affected by the traumatic event and encourage parents to listen to their children, talk about the trauma with their children, reassure them of their safety, respect their privacy, help them with day-to-day activities, and deal with their emotions in constructive ways.

Shen and Sink's (2002) approach to counselors-as-consultants differs from Brock's (1998) for it stresses the importance of educating family members as well as school staff on some key points for helping youngsters cope with an isolated traumatic event. The authors' suggested that counselors-as-consultants should encourage teachers, parents, school principals, and family members to quickly foster open communication with children, provide honest information about the traumatic event, use open questions in an effort to make clear feelings and anxieties, and stress the overall positive nature of humanity. In addition, children should be provided with a forum to mourn the loss of a loved one, a pet, or even something as simple as a toy, while supporting them if the assistance of a trained mental health specialist is needed. Overall, youngsters who are facilitated in their coping and processing by family members, school personnel, and counselors have an increased chance for long-term emotional stability.

SUMMARY

Unfortunately, we all live in a more violent world. Because of the advent of telecommunications and the Internet, natural disasters and violent events (i.e., wars, terrorist attacks) are emotionally felt and experienced farther and farther from their epicenters. As much trouble as adults have with understanding how and why someone would crash an airplane into a building or why some higher power would allow more than 150,000 people to perish in a tsunami, these catastrophes and their impact are exponentially intensified in children and adolescents. Most children and adolescents do not possess the maturity, cognitive development, and emotional stability necessary to handle these scenarios as compared to most adults. For these reasons, couples and family counselors are positioned to help young survivors and witnesses of traumatic events cope with their fear, confusion, anger, or deep sadness. Couples and family counselors also can intervene directly, using CBT, crisis counseling and CISD, play therapy, or psychoeducational groups, as well as consult with adults in school settings and family members. Although the short-term benefits and improvements for these children and adolescents may not be overtly and immediately observed, the long-term outcomes from receiving some kind of counseling assistance go a long way in helping youngsters cope with such traumatic and horrifying events.

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